MONTANA
Department of Public Health & Human Services

December 3, 2007

Montana Medicaid Notice

Physicians, Mid-Level Practitioners and Pharmacies

Carisoprodol (Soma®) Containing Products to Require Prior Authorization

Prior Authorization Criteria

Effective January 2, 2008, Montana Medicaid will be implementing the following Prior Authorization Criteria for the use of carisoprodol containing products:

- *New* prescriptions—Patient must have tried and failed on at least two other centrally-acting muscle relaxants (i.e. methocarbamol, tizanidine, cyclobenzaprine, orphenadrine, chlorzoxazone or Skelaxin®).
- Prior authorizations may be granted for a maximum of 84 tablets in a six-month time period.
- *Renewal requests*—A 30-day authorization will be granted for patients currently taking carisoprodol to allow for a tapering schedule. Patients on high doses may suffer withdrawal symptoms if stopped abruptly. Cases may be reviewed on an individual basis to allow for a longer tapering period.

Rationale for Requiring Prior Authorization

The Medicaid Drug Utilization Review Board has unanimously recommended implementation of Prior Authorization Criteria for carisoprodol-containing products based on a review of the evidence and literature. Carisoprodol is metabolized to the sedative meprobamate, a schedule IV controlled substance associated with the potential for dependence and addiction.

The prescriber (physician, etc.) or pharmacy may submit requests by mail, telephone, or FAX to:

Drug Prior Authorization Unit
Mountain Pacific Quality Health Foundation
3404 Cooney Drive
Helena, MT 59602
(406) 443-6002 or (800) 395-7961 (Phone)
(406) 443-7014 or (800) 294-1350 (Fax)

To request prior authorization, providers must submit the information requested on the attached Request for Drug Prior Authorization Form to the Drug Prior Authorization Unit.

Any questions regarding this notice can be directed to Wendy Blackwood at (406) 444-2738 or the Medicaid Drug Prior Authorization Unit at (406) 443-6002.

Contact Information

For claims questions or additional information, contact Provider Relations:

Provider Relations toll-free in- and out-of-state: 1-800-624-3958
Helena: (406) 442-1837

Visit the Provider Information website:

http://www.mtmedicaid.org

MOUNTAIN-PACIFIC QUALITY HEALTH FOUNDATION

Request for Drug Prior Authorization

Submitter: ☐ Physician ☐ Pharmacy **Please Type or Print**

PATIENT NAME (Last) (First) (Initial)		PATIENT MEDICAID I.D. NUMBER	DATE OF BIRTH
			MONTH DAY YEAR
PHYSICIAN PROVIDER #	PHYSICIAN PHONE #	DATES COVERED BY THIS REQUEST	
		FROM	TO
PHYSICIAN NAME		MONTH DAY YEAR	MONTH DAY YEAR
PHYSICIAN STREET ADDRESS		**MAIL, FAX OR PHONE COMPLETED FORM TO:**	
PHYSICIAN CITY STATE ZIP		**DRUG PRIOR AUTHORIZATION UNIT MOUNTAIN-PACIFIC QUALITY HEALTH 3404 COONEY DRIVE HELENA, MT 59602 (406) 443-6002 or 1-800-395-7961 (PHONE) (406) 443-7014 or 1-800-294-1350 (FAX)**	
PHARMACY PROVIDER NO.	PHARMACY PHONE #		
PHARMACY NAME			
PHARMACY STREET ADDRESS			
PHARMACY CITY STATE ZIP			

DRUG TO BE AUTHORIZED

DRUG NAME	STRENGTH	DIRECTIONS

DIAGNOSIS OR CONDITION TREATED BY THIS DRUG

LEAVE BLANK - PA UNIT USE ONLY

REASON FOR DENIAL OF DRUG PRIOR AUTHORIZATION

IMPORTANT NOTE: In evaluating requests for prior authorization, the consultant will consider the drug from the standpoint of published criteria only. If the approval of the request is granted, this does not indicate that the recipient continues to be eligible for Medicaid. It is the responsibility of the provider of service to establish by inspection of the recipient's Medicaid eligibility card and if necessary, by contact with Consultec to determine if the recipient continues to be eligible for Medicaid.

CURRENT RECIPIENT ELIGIBILITY MAY BE VERIFIED BY CALLING CONSULTEC AT 1-800-624-3958 or 406-442-1837.

APPROVAL OR DENIAL STATUS	DENIAL CODE	THERAPEUTIC CLASS	AUTH ID	DATE OF REQUEST	PRIOR AUTHORIZATION NUMBER